

## Fertility Questionnaire For Women

Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Birthdate \_\_\_\_\_

Husband's name \_\_\_\_\_

Telephone number at home \_\_\_\_\_

Telephone number at work \_\_\_\_\_

Other name and number to be called in an emergency \_\_\_\_\_

\_\_\_\_\_

Insurance company \_\_\_\_\_

Identifying numbers \_\_\_\_\_

Referring physician and address \_\_\_\_\_

\_\_\_\_\_

Age at first menses \_\_\_\_\_ Date of last menses (first day) \_\_\_\_\_

Usual menstrual interval \_\_\_\_\_ Usual duration of bleeding \_\_\_\_\_

Cramps (please circle)      Yes      No      Minimal      Moderate      Severe

Do cramps start before or after bleeding? \_\_\_\_\_

Are cramps always present?      Yes      No

Chronic headaches, history of head trauma, seizure disorder, problems with sense of smell, visual disturbances, dizziness, loss of balance.

Rapid or marked changes in weight, increased thirst, changes in appetite, increased sweating, chronically warm or cold, history of painful swallowing, change of voice or hoarseness, insomnia, fatigue, tremors, craving for salt, loss of scalp hair, growth of hair on face or body in new places or in excess, change in size of clitoris, diagnosis of thyroid disease, diabetes, history of breast secretions or milky discharge from nipples.

History of acquired or congenital heart disease, scarlet fever, rheumatic fever, diagnosis or treatment of high blood pressure.

## Background Information

Please underline or circle all responses that apply and fill in the blanks.

History of pulmonary (lung) disease such as tuberculosis, pneumonia, chronic bronchitis, emphysema, lung cysts or tumors.

## Background Information (continued)

Please underline or circle all responses that apply and fill in the blanks.

History of gall bladder problems, hiatal hernia, ulcer, appendicitis, colitis, regional enteritis, pancreatitis, jaundice, hepatitis, liver problems.

History of anemia, need for transfusion, arthritis, kidney infections, nephritis, Bright's disease, urinary tract abnormalities, frequent urination, auto-immune diseases.

History of any other serious or chronic illness (describe) \_\_\_\_\_

Duration of marriage? \_\_\_\_\_ Duration of infertility? \_\_\_\_\_

Either partner previously married? Yes No

Children from prior marriage? Yes No

How long to conceive? \_\_\_\_\_ (male) \_\_\_\_\_ (female)

Outcome of pregnancies:

Delivery, miscarriage, abortion Delivery, miscarriage, abortion

Year \_\_\_\_\_ Year \_\_\_\_\_

Complications: Yes No Complications: Yes No

Fever: Yes No Fever: Yes No

Previous methods of contraception: Pills Condoms Foam Diaphragm  
IUD Withdrawal Rhythm None

If pills, were menses regular before? Yes No

If pills, were menses regular after? Yes No

How long to resume menses when pills stopped? \_\_\_\_\_ weeks

If IUD, was device removed to conceive? For complications? (describe) \_\_\_\_\_

other? (describe) \_\_\_\_\_

Usual frequency of sexual intercourse per week \_\_\_\_\_

Lubricants used: Yes No Specify \_\_\_\_\_

**Background Information (continued)**

Please underline or circle all responses that apply and fill in the blanks.

Does husband ejaculate during intercourse? Yes No

Does ejaculation occur outside vagina? Yes No

Does his semen leak out when you stand? Yes No

Do you douche before or after? Yes No

Is intercourse (coitus) painful to either partner? Yes No

Do you achieve orgasms? Never Rarely Usually Always

Has artificial insemination ever been suggested? Yes No Husband or Donor

History of Syphilis Gonorrhea Pelvic infection?

Do you work? Yes No

Type of work \_\_\_\_\_

Exposure to chemicals or x-ray in work or hobbies? Yes No

Smoking habits: Yes No Pack/day \_\_\_\_\_

Alcohol: Yes No Drinks weekly \_\_\_\_\_

History of use of marijuana, opium or other addictive drugs: Yes No

Medications used now or recently \_\_\_\_\_

History of therapeutic x-ray treatment (not for diagnosis) or anti-cancer drugs or drugs for arthritis: Yes No

Family History:

Father Alive Dead Cause \_\_\_\_\_  
Age \_\_\_\_\_

Mother Alive Dead Cause \_\_\_\_\_  
Age \_\_\_\_\_

Sister (s) Age (s) \_\_\_\_\_

Brother (s) Age (s) \_\_\_\_\_

History of family infertility caused by endocrine (hormonal) disorder? Yes No

Previous hospital admission (for any reason) Medical/Surgical

Where	When	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Previous  
Infertility  
Studies

History of psychiatric treatment: Yes No

Name of Doctor \_\_\_\_\_

Drug treatment: Yes No Hospital Admission: Yes No

Temperature charts: Yes No Normal: Yes No

Husband had semen analysis: Yes No Year \_\_\_\_\_ Normal: Yes No

Post-coital test for sperm survival in cervix: Yes No Normal: Yes No

X-ray of tubes and uterus: Yes No Year \_\_\_\_\_ Normal: Yes No

Laparoscopy (telescope in abdomen): Yes No Year \_\_\_\_\_ Normal: Yes No

D & C to examine uterine lining: Yes No Year \_\_\_\_\_ Normal: Yes No

Hysteroscopy (telescope in uterus): Yes No Year \_\_\_\_\_ Normal: Yes No

Immunologic testing for sperm allergy: Yes No Normal: Yes No

Hormonal tests: Yes No Results (if known): \_\_\_\_\_

Chromosomal (genetic studies) Tay-Sachs screening

Sickle cell screening Thyroid tests

Skin test for tuberculosis Year \_\_\_\_\_ Skull x-ray Year \_\_\_\_\_

Diabetic test Others \_\_\_\_\_

Any procedure on cervix such as biopsy cauterization, cryosurgery (freezing): Yes No

Any procedure on uterus, vagina, tubes, ovaries, or operations for inflammatory or infectious pelvic diseases, operations for adhesions or endometriosis: Yes No

Stimulation of ovulation with oral or injectable agents such as estrogens, Clomid, HCG, Pergonal, others: Yes No

Treatment of endometriosis with drugs: Yes No

Treatment of tubes with medication via uterus: Yes No

Artificial insemination: Husband Donor Yes No

User of fertility-promoting douches: Yes No

Previous  
Infertility  
Treatment